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October 23, 2009

Michael Gelder, Chairperson
Governor's Task Force on Nursing Home Safety
100 West Randolph Street–Suite 16-100
Chicago, Illinois 60601

Re: Follow up on the October 20, 2009 Task Force hearing

Dear Chairperson Gelder

I thought that the hearing on October 20th was quite productive and appreciate the opportunity to address you and the other members of the Task Force. I want to follow up on the discussion about "money follows the person' because I think this issue needs clarification:

Everyone seems to agree that "money follows the person" is a good concept for thinking about how to make some cost-effective improvements in the mental health system and reduce our reliance on nursing homes. However, let me articulate why our Medicaid system does not encourage, but rather discourages, the movement of persons with mental illnesses out of nursing homes and into appropriate community care. The rates paid by the state and the failure to provide adequate mental health services in nursing homes means that nursing homes *make* money on every client. Nursing homes are a lucrative investment, in part, because the Illinois Department of Public Health has failed to force them to provide adequate mental health services to residents. Most of what is wrong with nursing homes is the result of inadequate staffing which exists due to lack of oversight.

Compare this to our community mental health system. The Medicaid rates and the things our Medicaid system is (un)willing to pay for mean that community mental health providers *lose* money on every client and almost every service. That is why almost all community mental health services are provided by not-for-profit entities who supplement Medicaid reimbursement with outside funding sources. The losses are amplified as providers serve people who require more case coordination, assistance with appointments, community supports, and other services that are generally not reimbursable.

Here are two examples of our inadequate rate structure in community mental health:

(a) Psychiatric services. The rate Medicaid pays for psychiatrists means that almost no psychiatrist in the state is willing to treat Medicaid patients without an outside subsidy. Community mental health providers need to have a psychiatrist on staff (or otherwise available to them). The only way they can arrange for this is to supplement the reimbursement the psychiatrists receive from Medicaid with other funds. The Department of Human Services has long recognized this problem and has responded by using Federal Block Grant funds to provide "psychiatric leadership grants" to community providers to help defray these costs. But using this funding stream does not solve the problem for many providers. Providers still lose money on every hour of responsible psychiatric Care. For some providers, these losses total hundreds of thousands of dollars every year.

(b) Assertive Community Treatment. This treatment modality, which has been widely researched and is truly evidence-based, is a necessary component of any effort to provide services to people currently in nursing homes. The administrative and Medicaid compliance burdens are so high relative to the rate which the state pays for this service that only a tiny percentage of those persons needing ACT are receiving it. It is simply not possible to provide this service in fidelity to the evidence-based model if one must rely solely on the rate currently paid by the state and live within the precise definition and state Medicaid rules for ACT. Those few providers willing to offer this treatment must find outside financial support to do so. DHS appears to have responded to this reality by creating a watered-down version of ACT which they call Community Support Teams (CST). The evidentiary basis for CST is at best weak and CST is not an adequate treatment modality for many of the people who need ACT level services including many people who could be discharged from nursing homes with the more robust ACT modality.

Unfortunately, other evidenced-based and cost-effective mental health services, which are needed to maintain persons with serious mental illnesses in the community, are either not reimburseable under Medicaid or are reimbursed at a

rate which does not cover the true cost of providing these services. In 2007, the University of Illinois Institute of Government and Public Affairs found that state payments covered only 74-79% of agency costs for community services. Since then, there have been no rate increases. Thus, the under-funding which existed in 2007 is worse now. In fact there have been cuts to community services, while rates have increased for intermediate care providers. Until recently some of these services were supported by the annual grants given to community mental health providers. However, DHS has responded to the current state budget crisis but reducing or eliminating funding for services which are not Medicaid eligible.

The simplest and most accurate way to summarize the above is:

The money DOES NOT follow a person leaving an IMD

Sincerely,

Mark J. Heyrman, Chair
Public Policy Committee
Mental Health America of Illinois